FLEXIBLE BENEFITS ENROLLMENT FORM

Allegiance℠ Flex Advantage
P.O. BOX 4346 • MISSOULA MT 59806
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www.allegianceflexadvantage.com

Please print clearly

EMPLOYER:	DIVISION:
SSN:	□ OPEN ENROLLMENT □ NEW HIRE □ CHANGE* EFFECTIVE DATE (mm/dd/yy):
NAME:	BIRTH DATE (mm/dd/yyyy):

MAILING ADDRESS:	PHONE:	□ M □ F	□ Married □ Single
CITY: STATE: ZIP:	EMAIL:		

If you have not already signed up for direct deposit, it's easy. Visit the Allegiance flex website www.allegianceflexadvantage.com.

FLEXIBLE BENEFITS ELECTION AUTHORIZATION

DEDUCT INSURANCE PREMIUMS PRE-TAX		PER PAY PERIOD DEDUCTION	♦ NUMBER OF PAY PERIODS	TOTAL ANNUAL AMOUNT ELECTED
□ YES □ NO	MEDICAL SPENDING	_____	X _____ =	_____
	DAYCARE	_____	X _____ =	_____

♦ PAY PERIODS - 52 = WEEKLY 26 = BI-WEEKLY (every 2 weeks) 24 = SEMI-MONTHLY 12 = MONTHLY

The "per pay period deduction" will be used to enter election amounts in the Allegiance system.

DEBIT CARD ELECTION AUTHORIZATION (IF OFFERED BY YOUR EMPLOYER)

□ Yes, I would like the flex debit card for the current plan year. ***Please provide an email address to receive debit card communications via email.***

□ Yes, I would like a card for my spouse. Check only if your employer allows spouse cards.

Name of spouse:_____ SSN:_____ Birth date:_____

BY ELECTING THE FLEX DEBIT CARD:

1. I may only use the card to pay for eligible expenses and will acquire and provide all requested documentation for those expenses.
2. I may not seek reimbursement under any other plan for expenses paid with the card.
3. I have been provided an explanation of the fees associated with the debit card.

CERTIFICATION ***I certify that these are my benefit elections and that*** **:**

1. I authorize the "before-tax" deduction of a portion of my pay based on the elections above.
2. My health FSA election is for medical, dental, and vision expenses for myself, my spouse, and my qualified dependents.
3. My daycare FSA election is for the care of my tax dependent children, under age 13, or individuals unable to care for themselves, residing with me at least 8 hours each day.
4. I understand that my unused contributions made to the FSA cannot be refunded to me and become the property of my employer.
5. Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense.
6. I understand that coverage applies only to expenses incurred within the plan year and during my period of employment.
7. I understand that this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in status.

Both an employee signature and company authorization are required for enrollment to be completed.

Signed: _____ Date: _____

Company Authorization: _____ Date: _____

***If this is an election change, please indicate the qualifying event:**

_____ HR initials _____

For Allegiance use only

Group Number: _____ Date Completed: _____ Entered By (initials): _____